Louisiana Medicaid
Ranolazine (Ranexa®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for ranolazine (Ranexa®).

Additional Point-of-Sale edits may apply.

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of chronic angina; **AND**
- Previous use of a preferred product – **ONE** of the following is required:
    - The recipient has had a *treatment failure* with **AT LEAST ONE** preferred calcium channel blocker, beta blocker or nitrate; **OR**
    - The recipient has had an *intolerable side effect* to **AT LEAST ONE** preferred calcium channel blocker, beta blocker or nitrate; **OR**
    - The recipient has *documented contraindication(s)* to **AT LEAST ONE** preferred calcium channel blocker, beta blocker or nitrate; **OR**
    - There is *no preferred calcium channel blocker, beta blocker or nitrate that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The maximum daily dose does not exceed 1000mg twice a day; **AND**
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of initial and reauthorization approval: 12 months

References

Ranexa (ranolazine) [package insert]. Foster City, CA: Gilead Sciences, Inc.; October 2019. https://www.gilead.com/-/media/files/pdfs/medicines/cardiovascular/ranexa/ranexa_pi.pdf

Rousan, Talla A, and Udho Thadani. "Stable Angina Medical Therapy Management Guidelines: A Critical Review of Guidelines from the European Society of Cardiology and National Institute for Health and Care Excellence." European cardiology vol. 14,1 (2019): 18-22. doi:10.15420/ecr.2018.26.1

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